

COPY



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR  
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T. – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0036  
PHONE: (208) 334-6626  
FAX: (208) 364-1888

September 9, 2009

Steve Silberberger  
Seven Oaks Community Homes - Cleveland  
3940 West 5th Avenue #C  
Post Falls, ID 83854

RE: Seven Oaks Community Homes - Cleveland, Provider #13G049

Dear Mr. Silberberger:

This is to advise you of the findings of the Medicaid/Licensure survey, which was conducted at your facility, Seven Oaks Community Homes - Cleveland, on September 3, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, which states that no Federal deficiencies were noted at the time of the survey.

Also enclosed is a Statement of Deficiencies/Plan of Correction form listing State Licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.
2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
3. Identify the date each deficiency has been, or will be, corrected.
4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **September 22, 2009**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

<http://www.healthandwelfare.idaho.gov/site/3633/default.aspx>

This request must be received by September 22, 2009. If a request for informal dispute resolution is received after September 22, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



MICHAEL A. CASE  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

MC/mlw

Enclosures

IDHW

9/28/2009 8:44:56 AM

PAGE 4/007

Fax Server

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 09/08/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/03/2009
NAME OF PROVIDER OR SUPPLIER  SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND STREET POST FALLS, ID 83854	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	<p>INITIAL COMMENTS</p> <p>Seven Oaks - Lynnwood is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Persons with Mental Retardation.</p> <p>The survey was conducted by: Michael Case, LSW, QMRP, Team Leader Jim Troutfelter, QMRP</p>	W 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Shirley Peltz*

TITLE

*Program Director*

(X6) DATE

9-30-09

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 09/08/2009  
FORM APPROVED

## Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13GD49	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ D. WING _____		(X3) DATE SURVEY COMPLETED  09/03/2009
NAME OF PROVIDER OR SUPPLIER  SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND STREET POST FALLS, ID 83854		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
MM380	<p>16.03.11.120.03(a) Building and Equipment</p> <p>The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents.</p> <p>This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 4 of 4 individuals (Individuals #1 - #4) residing in the facility. The findings include:</p> <p>During an environmental survey conducted on 9/1/09 from 10:40 - 10:55 a.m., the following concerns were noted:</p> <ul style="list-style-type: none"> <li>- There was an 8 inch by 4 inch patched section of wall to the right of the dining room window that was missing paint.</li> <li>- There was a 12 inch by 4 inch section of wall to the left of the dining room window that was missing paint.</li> <li>- There were two 2 inch by 3 inch rips on the bottom of the love seat cushion.</li> <li>- There was a 6 inch by 6 inch patched section of wall to the left of the laundry room door that was missing paint and the patched area was cracked.</li> <li>- There was a 3 inch round hole in the bottom right of the wall dividing the living room and kitchen.</li> </ul>	MM380	<p>MM380</p> <p>Each of the identified items has been noted on the facility's maintenance record and will be corrected. New furniture is on order and is expected to be delivered by October 15, 2009. All repairs and maintenance will also be completed by October 15, 2009.</p> <p>Completion Date: October 15, 2009 By Whom: Administrator</p>		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

DOB DATE

STATE FORM

0090

DBK11

If continuation sheet 1 of 2

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G049</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/03/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>SEVEN OAKS COMMUNITY HOMES - CLEVEL/</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3732 NORTH CLEVELAND STREET POST FALLS, ID 83854</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	<p>Continued From page 1</p> <ul style="list-style-type: none"> <li>- There was a 1 inch hole in the wall below the shower head in the hall bathroom.</li> <li>- There was a 2 inch hole in the wall to the right of the linen closet in the hall bathroom.</li> <li>- Individual # 4's window blind was broken from the mounting brackets.</li> <li>- The lock on the sliding glass patio door was loose.</li> <li>- The trim on the right side of the garage door was bowed.</li> <li>- The pads on the glider rocker in the back yard were torn.</li> </ul>	MM380		